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EVALUATION OF FAMILY PLANNING PROGRAMMES IN ECA MEMBER STATES

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I. INTRODUCTION

1. One of the most important of the many population problems currently facing the African continent is that of rapid population growth and its impact on economic, social and technological development. This situ tion is the direct consequence of the spectacular decline in mortality over the past two decades coupled with relatively high birth and fertility rates.

2. Africa is the continent with the highest population growth rate in the world. According to the latest United Nations estimates, the population of Africa grew by three per cent per year during the period 1980-1985 while the world average was 1.7 per cent. The corresponding growth rates for the other regions were: Europe, 0.3 per cent, North America, 0.9 per cent, Asia, 1.7 per cent, Latin America, 2.3 per cent, and Oceania, 1.5 per cent. 1/

3. Africa has high motality and morbidity rates. Life expectancy at birth has certainly increased from 37.3 years in 1950-1955 to 48.6 years in 1975-1980. These figures, however, show a level of mortality which is relatively still high when compared to the fact that life expectancy at birth was 73 years in Europe during the period 1975-1980 and 55.1 years for developing countries as a whole during the same period. The rates of maternal and childhood mortality are still high in Africa. Health facilities are concentrated in urban areas to the detriment of rural areas where the bulk of the population lives. Infectious diseases, parasites and malnutrition remain the main causes of death.

4. The relatively high birth rate on the continent is reflected by a crude birth rate of 46 per 1000 during the period 1980-1985 compared to that recorded for developing countries as a whole (34-41 per 1000). East Africa and West Africa have the highest birth rates (49 per 1000), followed by Central Africa (45 per 1000), North Africa (42 per 1000) and Southern Africa (40 per 1000). 2/

5. Possible solutions to these problems have touched off considerable controversy and the debate focussed on whether it was better to promote economic or demographic solutions.

6. The Second African Population Conference (Arusha 1984) and the International Conference on Population (Mexico City 1984) showed, however, that this debate was now quite outdated. In the Kilimanjaro Programme of Action for African Population and Self-Reliant Development adopted at Arusha African countries recognized that the rapid rate of population growth in recent years and the stresses and strains which this increasingly imposes on African Governments' development efforts posed a problem. Recommendation 23 of the Kilimanjaro Programmes of Action requests African Governments to ensure the availability and accessibility of family planning services to all couples or individuals seeking such services freely or at subsidized prices.

1/ United Nations, World Population Prospects, Estimates and Projections as assessed in 1982, New York, 1985.

2/ United Nations, op.cit.

7. The variety of economic and political systems in Africa has inevitably to divergent positions with respect to population policies and programmes and consequently a variety of strategies for designing and implementing such policies and programmes.

8. The five countries covered by the study have all opted for policies of direct government intervention through the implementation of family planning programmes. The programmes were officially launched in 1964 in Tunisia, 1966 in Egypt, 1967 in Kenya and Morocco and 1969 in Ghana.

9. The family planning programmes could be assessed simply by finding out whether they are attaining their objectives and, if not, the reasons why they are not doing so. However, the question of assessment raises a number of problems.

II. SOME PROBLEMS OF EVALUATION

10. The main theoretical questions posed by the evaluation of population programmes include the selection of evaluation criteria and the distinction that has to be made between the effects of the programmes and non-programme influences.

2.1 The selection of evaluation criteria

11. When it comes to carrying out a comparative study on the achievements of various national programmes, it becomes difficult to select evaluation criteria because the programmes do not have uniform objectives which could be used as a basis of agreement on the most decisive criteria.

12. The most commonly used evaluation criteria can be classified into three main categories based on the classification of Lapham and Mouldin. 3/ The three main criteria are statistical, programmatic and socio-economic.

(a) Statistical criteria

Statistical criteria are used to assess family planning objectives and population trends. In this case the widest range of quantitative measures and reliable chronological series providing frames of reference over time would have to be made available. It is, however, important to be able to determine the degree to which the changes observed are attributable to the programmes.

(b) Programmatic criteria

Such criteria which are not very easy to quantify make it possible to determine to what extent family planning programmes are supported by the public authorities. It is then assumed that the determination to support family planning programmes could make them successful while the lack of such determination would explain, to a large extent, the poor achievements.

3/ Robert J. Lapham and W. Parker Mouldin - "Une evaluation des programmes nationaux de planning familial." O.C.D.E., 1972.

(c) Social and economic criteria

The use of social and economic criteria is based on the idea that the social and economic setting in which population programmes are implemented is generally related to fertility decline. Fertility changes result from varying combination of many factors - social, economic, cultural, religious and demographic.

2.2 Differentiating between the effects of family planning programmes and the effects of other factors

13. The methodological problems involved in making the necessary distinction between the effects of family planning programmes and those of other factors have still not been resolved and even if they are solved theoretically, it will be difficult to apply the solutions in countries that have incomplete data.

14. The United Nations has suggested a classification of methods for measuring family planning programme impact on fertility and we will briefly present the following: standardization approach, trend analysis; expertimental designs; couple of years of protection, regression analysis; and simulation models. 4/

(a) Standardization approach

The approach requires two steps. The first step consists in measuring fertility at two points in time to determine whether any change has occurred. The second step consists in trying to account for the observed change, if any, by standardizing for various non-programme components.

(b) Trend analysis

Trend analysis is used to estimate, on the basis of reasonable assumptions, how fertility would have evolved had the family-planning programme not been undertaken. This potential trend is then compared with the actual trend and an attempt can be made to interprete the difference between the two trends.

(c) Experimental designs

The experimental-design approach compares two groups of population: the 'experimental group' covered by the programme and 'control group' which is assumed to have the same characteristics as the experimental group except that it is not covered by the programme.

4/ United Nations - Methods of Measuring the Impact of Family Planning Programmes on Fertility: Problems and Issues, Population Studies, No. 61, 1978, ST/ESA/ESA/SER.A/61.

(d) Couple years of protection (CYP)

The couple years of protection index (cyp) is used to assess the impact of the programme in a given period. The CYP number of each contraceptive method used is calculated and then the total is added up. From the foregoing, the number of births averted can be calculated on the basis of the equation 1 CYP = n births averted (n changes according to the country).

(e) Regression analysis

The method consists in determining an equation or system of equations where the dependent variable is a fertility indicator and the independent variables are programme and non-programme factors. Through such a functional model an attempt can be made to calculate the weight of the various independent variables in explaining differences in the dependent variable.

15. The problem of selecting methods should normally be settled when one wants to assess a specific programme. The methods are not mutually exclusive; several selection criteria could be used such as: evaluation objectives; the target population; availability of data; the independence of the method and the cost of the method.

16. This brief review of evaluation criteria and methods shows that the problem of assessment is still complicated. In developing countries in general and in African countries in particular, it is often impossible to secure the data required to include all the relevant criteria or to select the most appropriate method.

17. With respect to evaluation criteria, statistical criteria will mainly be used for the following three reasons:

(a) the main drawback of programmatic criteria is that they are too subjective to be applied to other criteria;

(b) to use economic and social criteria, the problem of determining economic and social thresholds has to be solved beforehand. This problem is all the more difficult to solve because the social and economic conditions in which population dynamics occur differ from country to country;

(c) The use of statistical criteria is facilitated by the availability in the countries studied of data from national fertility surveys carried out under the World Fertility Survey.

18. With respect to methods to measure the impact of family planning programmes on fertility, the main reason why we prefer not to use them in the following evaluation is because the exercise can be carried out in only two countries, Tunisia and Egypt; the data required are not available in the other three countries. The evaluation of population trends will therefore be limited by the fact that no attempt will be made to differentiate between programme and non-programme factors affecting fertility.

19. The approach which will be used will consist mainly of comparing population objectives and family planning objectives with the results obtained from national surveys on fertility. Such surveys were implemented in 1977-78 in Kenya, in 1978 in Tunisia, in 1979-80 in Ghana and Morocco and in 1980 in Egypt. The advantage of these surveys is that not only are the results representative at the national level but also basic concepts are perfectly comparable from country to country.

20. The results of these surveys will make it possible to evaluate some family planning targets (knowledge and practice of contraceptive methods by women of a child-bearing age, the desire to have more children, desired family size, and to evaluate the main population objectives (population growth, birth, fertility and mortality trends).

21. Let us now present very briefly the main population and family planning objectives of the various programmes.

III. POPULATION AND FAMILY PLANNING OBJECTIVES

3.1 Egypt

22. The aim of the ten-year family planning programme (1968-1978) was to reduce the birth rate by a point each year so that the crude birth rate would be 30 per 1000 in 1978 which brought the natural growth rate to about 1.7 per cent during the same period.

23. The new objectives of the population policy inaugurated in 1973 were the following:

(a) To reduce the population growth rate from 2.6 per cent in 1973 to 1.06 per cent in 1982;

(b) To reduce the crude birth rate from 33.7 per 1000 in 1973 to 23.6 per 1000 in 1982;

(c) To ensure that in future the crude death rate would not be above the rate of 13 per 1000 observed in 1973;

(d) To ensure that the population remained at 41 million in 1982;

(e) To reduce the legitimate fertility rate from 236 per 1000 in 1972 to 160 per 1000 in 1982 - a reduction of 7.6 per cent per year;

(f) To increase the rate of protection through contraception in 1982 to 25 per cent of the rural population and 35 per cent of the urban population.

3.2 Ghana

24. The programme adopted in 1970 often contained very general objectives. The only quantitative objectives were the following:

(a) Achieving in the long run a decline in the population growth rate from 3.9 per cent in 1970 to 1.7 per cent by the year 2000;

(b) Reducing the total fertility rate to four in the year 2000;

(c) Achieving a rate of protection through contraception of 10 per cent between 1970 and 1975.

3.3. Kenya

25. Kenya's 1972-1976 five-year family planning programme had the following targets.

(a) Reducing the crude-birth rate from 48 per 1000 in 1974 to 43 per 1000 in 1979 by getting 640,000 people to use methods of contraception;

(b) Reducing the infant mortality rate by 30 per cent and the juvenile mortality rate by 50 per cent;

(c) Reducing the population growth rate from 3.5 per cent in 1972 to 3.25 per cent in 1979,

(e) In the long run, achieving a more drastic reduction in the population growth rate: 3 per cent in 1980 and 2.8 per cent in the year 2000 and thus reducing the total fertility rate to 4.7 in the year 2000.

3.4 Morocco

26. The national family planning programme established in 1967 had only one quantitative objective stated in the 1968-1972 development plan, namely: to reduce the crude-birth rate from 50 per 1000 in 1968 to 45 per 1000 in 1972 and then to 35 per 1000 in 1985.

27. In the 1981-1985 development programme, the Ministry of Public Health set itself another quantitative objective of attaining a prevalency rate of 24 per cent in 1985.

3.5 Tunisia

28. The programme adopted in 1966 had the following targets:

(a) Reducing the crude birth rate from 46 per 1000 in 1966 to 36 per 1000 in 1971 and then to 34 per 1000 in 1975;

(b) Achieving a prevalency rate of 40 per cent for women between 20 and 40 years of age.

29. The National Family Planning and Population Board established in 1973 adopted a three year programme with the following quantified objectives:

(a) Reducing, by the year 2000, the age-group fertility rates of Tunisia to the same level as those observed in 1970 in Italy,

(b) Reducing the population growth rate from 1.8 per cent in the period 1971-1976 to 1.1 per cent in the period 1996-2001.

30. The medium-term objectives of the Fifth Development Plan (1977-1981) were the following:

(a) Bringing about a decline in the birth rate from 35.3 per 1000 in 1976 to 32.3 per 1000 at the end of the Plan (1981) then to 29.9 per 1000 in 1986;

(b) Reducing the fertility rate from 155.1 per 1000 in 1976 to 135.3 per 1000 in 1981 then to 120 per 1000 in 1986.

31. The aim of the Sixth Plan (1982-1986) is to achieve an increase in the rate of contaceptive usage from 27 per cent in 1980 to 40 per cent in 1986.

IV. EVALUATION OF PROGRAMME OBJECTIVES

4.1 Evaluation of family planning objectives

4.1.1 Women and family planning

32. Table 1 shows that the percentage of ever-married women who indicated having any knowledge of contraceptive methods varies between 69 per cent in Ghana and 95 per cent in Tunisia. Data classified by age show that in all the countries concerned, women who are between 25 and 34 years of age are the ones who know contraception best. These results show the emphasis and direction that should be given to the campaign to make women aware of the use of contraceptions especially in Ghana and to a lesser extent in Morocco.

33. With respect to knowledge of and access to family planning guidance facilities, the following findings generated by national fertility surveys indicate once more that official family planning campaigns still do not have enough impact in some of the countries studied.

34. In Ghana, 66 per cent of the ever-married women did not have any source of information on family planning at the time of the survey. The percentage observed in Kenya was 58 per cent in 1977-78. In 1978-79, there were only five per cent of the ever-married women who had been to family planning guidance offices in Ghana while in Kenya that percentage was 12 per cent in 1977-78.

35. In Morocco and Egypt, the percentages of women who did not know of any sources of supply of contraceptive methods were 18 per cent and 25 per cent respectively.

36. Knowledge of contraceptive methods does not automatically lead to the use of contraceptives. The findings of the surveys on fertility make it possible to compare the results obtained with respect to family planning for various categories of women with the initial objectives.

Table 1. Percentage of age specific ever-married women who have heard about contraceptive methods

Countries	Current age				Total
	25	25-34	35-44	45+	
Egypt	85	92	91	89	90
Ghana	70	72	67	62	69
Kenya	91	92	92	88	91
Morocco	81	86	88	84	84
Tunisia	93	97	96	92	95

Source. National fertility surveys

37. In Egypt, the target of attaining a rate of protection through contraception of 35 per cent in urban areas in 1982 had already been exceeded by 1980 when a rate of 52 per cent was achieved. However, the prevalency rate of 16 per cent observed in rural areas during the same year indicates that it will be almost impossible to attain the expected target of 25 per cent in 1982.

38. In Ghana, the objective of insuring that by 1975, 10 per cent of the women of a child-bearing age will use contraception does not appear to have been attained either since in 1979-80 only six per cent of married and fertile women used modern contraceptive methods.

39. Morocco and Tunisia appear, on the other hand, to have attained their objective in this respect. Indeed, although the results of the fertility survey in Morocco indicate that the rate attained in 1979-80 was 19 per cent, the preliminary results of the 1983-84 national survey on contraceptive prevalence give on the other hand a prevalency rate of 25.5 per cent at the end of 1983. Thus, the objective of 24 per cent in 1985 had already been exceeded as early as 1983. The same thing happened in Tunisia where the EPS-ONPFP survey of 1983 showed that the prevalence rate attained a very appreciable level in 1983, i.e. 41 per cent of the level expected under the 6th plan for 1986.

40. The most popular contraceptive methods are the pill (Egypt, Ghana, Kenya, Morocco) and the Intra-Uterine Device (Tunisia).

41. To sum up, Tunisia is the only one of the five countries covered by the study where the prevalence rate appears to be sufficient to influence population trends. Indeed, it has been demonstrated that to alter such trends appreciably, more than 33 per cent of married women of child-bearing age should use contraception.

4.1.2 Women and the number of children desired

42. Table A 1 in the annex on the average number of children desired by married women shows that Ghanaian and Kenyan women still desire large families. Thus, the ideal size of the family desired by the women was at the time of the survey, seven children in Kenya and six in Ghana while it was five in Morocco and four in Egypt and Tunisia.

43. Moreover, generally speaking, the Ghanaian and Kenyan women still wanted on the average more children than the number of living children they had when the survey was carried out.

44. This shows the slight impact of the sensitization campaigns in Kenya and in Ghana despite the fact that from the very outset, the family planning programme in the two countries stressed the reduction of family size and the importance of spacing births.

4.2 Evaluation of population objectives

4.2.1 Population growth

45 The data presented in Table 2 make it possible to follow the changes in the rate of population growth as observed during the last two decades in each of the countries.

Table 2. Annual mean inter-censal growth rate (%)

Egypt		Ghana		Kenya		Morocco		Tunisia	
Year	Rate	Year	Rate	Year	Rate	Year	Rate	Year	Rate
1960	2.3	1960	2.7	1962	3.0	1960	2.5	1956	1.7
1966	2.4	1970	3.0	1969	3.3	1971	2.6	1966	1.8
1976	2.4	1980	3.2	1979	3.9	1982	2.6	1975	2.3
1982	2.8			1980	4.0			1980	2.7

Source: Egypt, Ghana, Tunisia: National fertility surveys (Vol. I)
Kenya: Integrated Rural Helth and Family Planning Project. Plan of Implementation, 1983, p.4.
Ghana: National Seminar on Population, Employment and Development, 1977, p. 16.

46. It can be seen that, contrary to the objective persued, the population has grown everywhere at increasingly higher rates. Several explanations have been given to this. 5/

47. In Morocco and Ghana the decline in mortality is accompanied by high levels of fertility. In addition, in Ghana the increase in population has been attributed in part to immigration. In Kenya, the accelerated population growth is thought to be due to the fact that the decrease in mortality has been accompanied by a rise in fertility. In Tunisia, the trend observed is thought to be due to the spectacular decrease in ortality which is declining faster than the decline in fertility. In Egypt, the increase in the population growth rate over the last few years is thought to be attributable to the baby bulge" after the wars especially that of 1967. This, coupled with the decline in mortality, contributed to the rise in the population growth rate.

4.2.2 Birth rate and fertility

4.2.2.1 Birth rate

All the countries studied except Ghana had a quantified objective of reducing their birth rates. But the data observed in Table A 2 in the annex to this document show that only Morocco and Tunisia are near to attaining these objectives. However, the success achieved with respect to bringing about a decline in the birth rate in Morocco could be attributed to the fact that Morocco's objectives were realistic.

48. It can thus be observed that the birth rate decreased in Egypt from 40 per 1000 in the 1960s to 34 per 1000 in 1972 but since then it has climbed steadily back to about 40 per 1000 once again. This trend shows that the objective of reducing the birth rate by a point every year was not achieved, thus, the projected target in 1982 of 23.6 per 1000 was not attained. The same thing happened in Kenya where the programme did not achieve a reduction in the crude birth rate from 48 per 1000 in 1974 to 43 per 1000 in 1979. The rate observed in 1979 was 53 per 1000.

49. In Tunisia, the downward trend in the crude birth rate has continued steadily since 1960. Yet, it was only from 1970 onwards that the rate dropped below 40 per 1000 to gradually attain 34.1 per 1000 in 1978, and thus make it possible to attain the target of 32.3 per 1000 in 1981.

4.2.2.2 Fertility

Each of the countries attempted, through its programme, to considerably reduce the fertility of couples and only Morocco did not have a quantified objective in that respect.

50. Table A 3 in the annex, which shows age-specific fertility rates at maternity for five-year periods makes it possible to follow fertility trends. These rates were calculated from maternity history data collected during the national fertility surveys. 6/

5/ See first analysis reports of the national fertility surveys.

6/ For details on the calculations, see. Brass, W. (1978) "Screening Procedures for detecting Errors in Maternity History Data," WFS/TECH 810, London.

51. The general impression given by Table A 3 is that there has been a recent decline in general fertility in each of the countries. It should, however, be emphasized that these retrospective estimates are sensitive to omissions and mis-dating of events and could thus distort the actual fertility trend.

52. If the empty spaces of Table A 3 are completed by the rates corresponding to same age in the adjacent periods, a total fertility series is obtained for each country.

53. The decline in fertility in Egypt was initially caused by rising age at marriage and this was followed by a period in which the proportion of married women and the rates of legitimate fertility both declined. 7/ The target of reducing the rate of legitimate fertility to 160 per 1000 in 1982 was however not attained because according to the findings of the fertility survey that rate was 241 per 1000 in 1980.

54. In Ghana, total fertility remained stable at around seven children until 1970 and then started to decline slightly from 6.97 to 6.47. The cohort rates per period do not appear to reflect such a trend and tend rather to indicate that fertility has remained stable in which case the impact of the population programme on fertility would be negligible. The same conclusion could be drawn in Kenya where the data indicate extremely high fertility levels. The estimated total fertility rates were 8.3, 8.9, 9.2 and 8.5 for the period 0-4, 5-9, 10-14 and 15-19 years prior to the survey, respectively. The impression of an increase in fertility up until the mid-1960s, followed by a decline is almost certainly a reflection of errors rather than genuine trends. 8/ Whatever the case might be, it would be very difficult to decrease by half total fertility which was as high as 8.3 in 1974-78 within a period of 20 years to 4.7 in the year 2000.

55. In Morocco, the objective of bringing about a decline in fertility seems to have started achieving a measure of success only in the recent past, i.e., during the period 1975-1979 when total fertility was 5.9 children compared to 6.9 children during the period 1970-1974. The decline in fertility was mainly among child-bearing women of between 15 and 25 years of age. As in the case of Egypt, this was probably caused by rising age at first marriage of the youngest generations and a decline in legitimate fertility after the age of 30. These two factors combined to bring about a considerable decline in overall fertility during the 1975-1979 period. 9/

56. In Tunisia a steady decline in fertility was observed during the two decades prior to the survey, i.e. since 1958. Here, the decline in fertility could be attributed in particular during the last fifteen years to joint action to raise the marriage age and to the use of contraception which was considerably developed during those years. 10/

7/ The Egyptian fertility survey, volume II, page 47.

8/ Kenya fertility survey, volume I, page 91

9/ National fertility and family planning survey in Morocco, 1979-1980, Vol. III, page 30.

10/ Tunisian fertility survey 1978, Vol. I, page 11.

The objective of attaining a general decline in fertility stated in the Fifth Development Plan could be said to have been achieved in 1981. Indeed, the objective was to reduce general fertility to 135 per 1000 in 1981; the fertility survey puts that index at 143 per 1000 for the period 1974-1978 while the estimates of the National Institute of Statistics put it at 149 per 1000 for 1978. The past trend of overall fertility rate could be used to support the assumption that the target rate for 1981 has been atained; that rate which was estimated at 200 per 1000 in the mid-1960s fell to 170 per 1000 and then to 148 per 1000 in 1978. Finally, although it is still too early to assess the long-term objective of attaining, by the year 2001, the age-specific fertility rates observed in Italy in 1970, the table below shows changes in the fertility rate in Tunisia since 1966.

Table 3. Changes in total fertility rates in Tunisia

Age Group	General fertility rates			Objective 2001 Rates Italy 1970
	1966	1971	1976	
15-19	73	46	39	22
20-24	296	273	201	104
25-29	350	321	295	156
30-34	316	287	232	108
35-39	236	214	190	98
40-44	114	102	95	18
45-49	31	30	25	2

Source: Tunisia, INS, Perspectives d'evolution de la population, 1971-2001.

57. A look at this table shows a steady decline in fertility rates at all ages between 1966 and 1976. Given the considerable decline in fertility during that decade, it could be hoped that if the trend continues at the same rate, the objective for 2001 could be attained within 25 years.

4.2.3 Mortality

Obviously, all the programmes stressed the need to bring about a rapid decline in mortality especially infant mortality. Only Kenya and Egypt, however, had quantified objectives.

58. As in all developing countries, the countries covered by the study recorded a very rapid decline in mortality rates during the past three decades through an improvement in health facilities, mass hygiene campaigns to combat endemic diseases. The data shown in Table A 2 give an idea of the extent of decline in mortality.

59. In Egypt, the general rates of mortality declined from 25 per 1000 during the 1940s to 19 per 1000 during the 1950s and then to 10 per 1000 in the early 1980s. The objective for 1978 was attained in 1973 because since then the crude mortality rate has been below 13 per 1000 (Table A 3).

60. Table 4, which shows infant and child death probabilities, confirms the steady and pronounced decline in child mortality over the past 20 years in conformity with the programmes' objectives. However, as it was stated earlier on, only Kenya quantified its objectives, i.e. a 50 per cent reduction in child mortality and 40 per cent reduction in infant mortality during the period 1972-79.

61. In 1977, the rate of infant mortality was 83 per 1000 in Kenya, as against a rate of 119 per 1000 given by the 1969 census. This matches the decline of 30 per cent envisaged by the programme; such a decline was also achieved in 9 years even though the periods of reference are slightly different. With respect to child mortality, the decline achieved over the past 10 years does not permit us to affirm that the objective of reducing mortality by 50 per cent has been attained.

Table 4. Infant and Child Mortality for five-year periods

Countries	Infant Mortality (years before survey)				Child Mortality (years before survey)			
	0-4	5-9	10-14	15-19	0-4	5-9	10-14	15-19
Egypt	132	146	141	161	191	238	243	283
Ghana	70	67	78	79	118	148	145	172
Kenya	83	88	96	121	139	148	157	196
Morocco	81	102	103	121	142	161	180	207
Tunisia	80	75	78	110	107	130	140	194

Source: National fertility surveys

V. SUMMARY AND RECOMMENDATIONS

62. One of the objectives of this paper was to focus the attention of African officials responsible for population programmes on the problems of evaluation.

63. We have seen that one of the main problems lay in selecting the most appropriate evaluation criteria and methods from the wide range available. There are a number of shortcomings such as the lack of reliable data and comprehensive chronological series and the lack of thorough investigations to pinpoint the impact of the programmes.

64. The evaluation structure that we have suggested is mainly based on the availability and comparability of data generated by national fertility surveys carried out within the framework of the World Fertility Survey. It was therefore a question of evaluating population and family planning programme objectives using the data generated by the national fertility surveys.

65. The limits of such an approach are quite obvious, but it enabled us to show that certain solutions could always be envisaged to make up for the lack of data required in selecting and implementing evaluation criteria and methods.

66. From the results obtained, it appeared that the impact of family planning programmes was relatively low in four of the five countries studied, namely Egypt,

Ghana, Kenya and Morocco. The case of Tunisia could be explained by the fact that the country's population policy is not only clear and well planned but it is also backed by relevant legislation and by political will at the highest level.

67. There are many reasons for the failure or poor performance of the programmes. The failure could be due to: the fact that the objectives were not clearly defined, inadequate financial, material and human resources; the poor motivation of the target population; the inadequacy of the evaluation, etc.

68. We, therefore, propose the following recommendations to improve the efficiency of the programmes:

(a) Improving knowledge of demography in the countries by promoting particularly the collection and analysis of data and training demographers and specialists in family planning;

(b) Defining more accurate family planning programme objectives by carrying out a realistic assessment of the requirements and demands of the target population;

(c) Establishing an autonomous executing agency for the programmes especially with respect to programme management;

(d) Providing consistent support to programmes at the highest political level;

(e) Encouraging governments to provide more consistent financial to the programmes;

(f) Ensuring the legislation plays a catalytic role and given the programmes a crucial legal framework;

(g) Developing a meaningful policy on information and incentives and a population education programme for the target populations, socio-professional categories and specific risk groups;

(h) Creating and developing genuine research and evaluation units within the programme implementation agencies;

(i) Promoting horizontal cooperation through the exchange of information and experiences among countries.

Table A1: Mean number of children desired by currently married women, by current age, duration since first marriage and number of living children

Countries	Current age							
	20	20-24	25-29	30-34	35-39	40-44	45-46	Total
Egypt	4,3	3,9	3,7	4,1	4,4	4,5	4,6	4,1
Ghana	5,2	5,2	5,5	6,3	6,9	7,2	7,3	6,1
Kenya	6,6	6,4	6,8	7,3	8,1	8,2	8,7	7,3
Morocco	4,3	4,4	4,6	5,0	5,4	5,6	6,1	5,0
Tunisia	3,7	3,7	3,9	4,2	4,4	4,5	4,4	4,2

	Years since first marriage						
	5	5-9	10-14	15-19	20-24	25-29	30 +
Egypt	3,6	4,0	4,1	4,2	4,7	4,8	4,8
Ghana	5,0	5,4	6,0	6,6	7,2	7,7	7,7
Kenya	6,3	6,6	7,3	7,7	8,3	8,8	8,6
Morocco	4,1	4,4	5,0	5,3	5,5	5,8	6,0
Tunisia	3,6	4,0	4,2	4,4	4,6	4,6	4,5

	Number of living children									
	0	1	2	3	4	5	6	7	8	9 +
Egypt	3,8	3,5	3,8	3,9	4,2	4,6	4,7	5,2	5,4	5,7
Ghana	5,3	5,0	5,3	5,7	6,2	6,9	7,4	8,0	8,9	9,9
Kenya	6,2	6,4	6,6	6,8	7.0	7,3	8,1	8,3	9.0	10,2
Morocco	4,2	4,1	4,2	4,5	5,1	5,2	5,2	6,1	6,5	6,7
Tunisia	3,7	3,4	3,6	3,8	4,3	4,7	4,7	4,7	5,0	4,8

Source: National fertility surveys

Table A2: Evolution of crude birth rates and crude death rates

	Crude birth rates					Crude death rates				
Year	Egypt	Kenya	Morocco	Tunisia	Year	Egypt	Ghana	Kenya	Morocco	Tunisia
1962	41,5	50	46,1	45,0	1962	17,9	23	20	19	
1963	43,0			43,0	1963	15,5				
1964	42,3			46,0	1964	15,7				
1965	42,7			44,0	1965	14,1				
1966	41,2			45,1	1966	15,9				16
1967	38,9			41,9	1967	14,2				
1968	37,9			41,1	1968	16,0				
1969	36,8	50		41,7	1969	14,4	20	17		
1970	35,0	)		38,8	1970	15,1				
1971	35,0	)		36,6	1971	13,1	18	)		
1972	34,3	)	46,8	39,0	1972	14,4		)		15
1973	35,7	)		36,9	1973	13,0		)		
1974	35,6	48)		35,6	1974	12,6		13)		
1975	36,0	)		36,6	1975	12,1		)		
1976	36,4			36,1	1976	11,7		)	15	
1977	37,3	54		37,2	1977	11,8		14)		
1978	37,3			34,1	1978	10,4		)		
1979	39,8	53		34,0	1979	10,8		14)		
1980	40,8			35,0	1980	10,4		)		8,8
1981	41,8				1981	10,2		)		
1982	36,9		38		1982	10,3		)		

Source: National fertility surveys

Table A3: Age-specific fertility rates (p.1000) by age at maternity and by five-year periods

Countries	Age at Maternity	Period (years before survey) 0-4	5-9	10-14	15-19	20-24	25-29	30-34
Egypt	15-19	99,3	122,0	164,3	197,0	205,5	199,2	176,6+
	20-24	255,5	267,7	324,8	349,8	325,8	366,8+	
	25-29	235,2	280,5	320,0	326,6		347,8+	
	30-34	217,4	220,9	251,0	297,0+			
	35-39	130,5	134,3	165,3+				
	40-44	48,2	66,0+					
	45-49	15,5+						
Total fertility rate		5,47	5,53	6,53	7,09			
Ghana	15-19	136	141	134	148	150	120	112+
	20-24	255	268	269	268	249	263+	
	25-29	276	281	295	281	292+		
	30-34	245	266	272	286+			
	35-39	188	211	245+				
	40-44	132	166+					
	45-49	61+						
Total fertility rate		6,47	6,97	7,21	7,27			
Kenya	15-19	178	158	209	210	177	163	118+
	20-24	345	356	379	320	303	300+	
	25-29	357	362	361	317	316+		
	30-34	297	328	352	322+			
	35-39	244	277	273+				
	40-44	164	166+					
	45-49	68+						
Total fertility rate		8,3	8,8	9,2	8,5			
Morocco	15-19	93	133	161	205	209	191	170+
	20-24	265	306	323	330	331	329+	
	25-29	296	328	328	320	339+		
	30-34	222	274	265	267+			
	35-39	170	197	209+				
	40-44	98	104+					
	45-49	29+						
Total fertility rate		5,9	6,9	7,1	7,3			
Tunisia	15-19	34	50	97	118	123	96	79+
	20-24	225	226	307	293	282	255+	
	25-29	304	323	340	337	350+		
	30-34	261	264	314	355+			
	35-39	199	212	233+				
	40-44	112	113+					
	45-49	37+						
Total fertility rate		5,8	6,2	7,1				

Source: National Fertility Surveys (Vol.I). + Incomplet cohorts.